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Robert Sherman
Director

MEMORANDUM

TO: Tom Docktor
Labor Cabinet

FROM: Emily Caudill
Regulations Compiler

RE: Administrative Regulation Amended After Comments – 803 KAR 25:091

DATE: March 12, 2009

A copy of the amended after comments administrative regulation, listed above, and the statement of consideration, are enclosed for your files.

This administrative regulation will be reviewed by the Administrative Regulation Review Subcommittee at its **April 2009** meeting. Please notify the proper person(s) of this meeting.

If you have any questions, please contact this office at 564-8100.

Enclosure

LABOR CABINET

DEPARTMENT OF WORKERS' CLAIMS

(Amended After Comments)

803 KAR 25:091. Workers' compensation hospital fee schedule.

RELATES TO: KRS 342.020, 342.035, 342.315

STATUTORY AUTHORITY: KRS 342.020, 342.035, 342.260

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.035 requires the Executive Director of the Office of Workers' Claims to promulgate administrative regulations to adopt a medical fee schedule for fees, charges and reimbursements under KRS 342.020. KRS 342.020 requires the employer to pay for hospital treatment, including nursing, medical, and surgical supplies and appliances. E.O. 2008-472, effective June 2, 2008, reorganized the Office of Workers' Claims as the Department of Workers' Claims and established the commissioner, rather than executive director, as the head of the department. This administrative regulation establishes the [~~regulates~~] hospital fees for services and supplies provided to workers' compensation patients pursuant to KRS 342.020.

Section 1. Definitions. (1) "Hospital" means a facility, surgical center, or psychiatric, rehabilitative or other treatment or specialty center which is licensed pursuant to KRS 216B.105.

(2) "Hospital-based practitioner" means a provider of medical services who is an employee of the hospital and who is paid by the hospital.

(3) "Independent practitioner" means a physician or other practitioner who performs services that are covered by the Workers' Compensation Medical Fee Schedule for Physicians on a contract basis and who is not a regular employee of the hospital.

(4) [~~"Unbundling" means the practice of submitting separate bills for services to a payor pursuant to this administrative regulation which are billed to payers other than pursuant to this administrative regulation on a global basis.~~

~~(5) "Global basis" means the practice of submitting a bill for two (2) or more services as one (1) item.~~

~~(6)~~] "New hospital" means a hospital which has not completed its first fiscal year.

(5) "Ambulatory surgery center" means a public or private institution that is:

(a) Hospital based or freestanding;

(b) Operated under the supervision of an organized medical staff; and

(c) Established, equipped, and operated primarily for the purpose of treatment of patients by surgery, whose recovery under normal circumstances will not require inpatient care.

Section 2. Applicability. This administrative regulation shall apply to all workers' compensation patient hospital fees for each hospital for each

compensable service or supply provided on or after February 2, 1993 [~~the effective date of this administrative regulation~~].

Section 3. Calculation of Hospital's Base and Adjusted Cost-to-charge Ratio; Reimbursement. (1)(a) A hospital's base cost-to-charge ratio shall be based on the latest cost report, or HCFA-2552, which has been supplied to the Cabinet for Health and Family Services, Department of Medicaid Services, pursuant to 907 KAR 1:815 [~~1:376~~] and utilized in 907 KAR 1:820 and 907 KAR 1:825 [~~1:013~~] on file as of October 31 of each calendar year.

(b) The base cost-to-charge ratio shall be determined by dividing the net expenses for allocation as reflected on Worksheet A, Column 7, Line 95, plus the costs of hospital-based physicians and nonphysician anesthetists reflected on lines 12, 13, and 35 of Worksheet A-8, by the total patient revenues as reflected on Worksheet G-2 of the HCFA-2552. **The adjusted cost-to-charge ratio shall be determined as set forth in paragraph (c) of this subsection.**

(c)**1.** [~~(2)~~] The base cost-to-charge ratio shall be further modified to allow for a return to equity by multiplying the base cost-to-charge ratio by 132 percent except that a hospital with more than 400 licensed acute care beds **as shown by the Office of Inspector General's website** or a hospital that is designated as a Level I trauma center by the American College of Surgeons shall have a return to equity by multiplying its base cost-to-charge ratio by 138 percent [~~the addition of twelve (12) percentile~~].

2. If a hospital's base cost-to-charge ratio falls by ten (10) percent or more of the base for one reporting year, then the next year's return to

equity shall be reduced from 132 percent to 130 percent or 138 percent to 135 percent as determined by paragraph (c)1. of this subsection. This reduction is subject to an appeal pursuant to Section 4 of this regulation. The Commissioner may waive the reduction for no more than one (1) consecutive year.

(d) 1. Except as provided in subparagraph 2. of this paragraph, a hospital's adjusted cost-to-charge ratio shall not exceed fifty (50) percent, including the return to equity adjustment.

2. The adjusted cost-to-charge ratio shall not exceed sixty (60) percent for a hospital that:

a. Has more than 400 licensed acute care beds;

b. Is designated as a Level I trauma center by the American College of Surgeons; or

c. Services sixty-five (65) percent or more patients covered and reimbursed by Medicaid or Medicare as reflected in the records of the Cabinet for Health and Family Services, Department of Medicaid Services.

d. Has a base cost-to-charge ratio of fifty (50) percent or more.

~~[(3) A hospital's adjusted cost-to-charge ratio shall not exceed eighty-five (85) percentile, including the twelve (12) percentile addition, except for a hospital that services seventy (70) percentile or more patients covered and reimbursed by Medicaid or Medicare as reflected in the records of the Cabinet for Health Services, Department of Medicaid Services. The adjusted cost-to-charge ratio for a hospital that services seventy (70) percentile or more patients covered and~~

~~reimbursed by Medicaid or Medicare shall not exceed ninety-seven (97) percentile.~~

~~(4) The~~] (2)(a) Except as provided in paragraph (b) of this subsection, the reimbursement to a hospital for services or supplies furnished to an employee which are compensable under KRS 342.020 shall be calculated by multiplying the hospital's total [~~allowable~~] charges by its adjusted cost-to-charge ratio **after removing any duplicative charges or billing errors/charges for services or supplies not confirmed by the hospital chart.**

(b) If part of a bill for services or supplies is alleged to be non-compensable under KRS 342.020 and that part of the bill is challenged by the timely filing of a medical fee dispute or motion to reopen, the non-contested portion of the bill shall be paid in accordance with paragraph (a) of this subsection.

Section 4. Appeal of Assigned Ratio. (1) Each hospital subject to the provisions of this administrative regulation shall be notified of its proposed base cost-to-charge ratio by the commissioner [~~executive director~~] by U.S. mail within thirty (30) days of the date the base cost-to-charge ratio is assigned by the Commissioner [~~Executive Director~~] of the Department [~~Office~~] of Workers' Claims.

(2) A hospital may request a review of its assigned ratio by filing a written appeal with the commissioner [~~executive director~~] no later than thirty (30) calendar days after the ratio has been assigned and hospital notified of its proposed cost-to-charge ratio.

Section 5. Revision of Hospital Cost-to-charge Ratio. (1)(a) The commissioner [~~executive director~~] shall calculate cost-to-charge ratios and notify

each hospital of its adjusted cost-to-charge ratio on or before February 1 of each calendar year.

(b) A new hospital shall be assigned a cost-to-charge ratio equal to the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals [~~of eighty (80) percentile~~] until it has been in operation for one (1) full fiscal year.

(c) A hospital that does not file Worksheets A and G-2 of HCFA 2552 shall be assigned a cost-to-charge ratio as follows:

1. A psychiatric, rehabilitation, or long-term acute care hospital shall be assigned a cost-to-charge ratio equal to the average adjusted cost-to-charge ratio of all in-state acute care hospitals;

2. An ambulatory surgery center shall be assigned a cost-to-charge ratio equal to:

a. Seventy (70) percent of the average adjusted cost-to-charge ratio of all acute care hospitals located in the same county as the ambulatory surgery center; or

b. If no acute care hospital is located in the county of the ambulatory surgery center, seventy (70) percent of the average adjusted cost-to-charge ratio of all acute care hospitals located in counties contiguous to the county in which the ambulatory surgery center is located; **or**

c. The adjusted cost-to-charge ratio of the hospital if the center is hospital based and is a licensed ambulatory surgery center or outpatient facility and is a Medicare provider based entity; and

3. All other hospitals not specifically mentioned in subparagraphs 1 and 2 of this paragraph shall be assigned a cost-to-charge ratio equal to:

a. The average adjusted cost-to-charge ratio of all acute care hospitals located in the same county as the facility; or

b. If there are no hospitals in the county, the average of all acute care hospitals located in contiguous counties [~~of eighty (80) percentile~~].

(2) An assigned cost-to-charge ratio shall remain in full force and effect until a new cost-to-charge ratio is assigned by the commissioner [~~executive director~~].

Section 6. Calculation for Hospitals **and Ambulatory Surgery Centers** Located Outside the Commonwealth of Kentucky. (1) A hospital **and ambulatory surgery center** located outside the boundaries of Kentucky shall be deemed to have agreed to be subject to this administrative regulation if it accepts a patient for treatment who is covered under KRS Chapter 342.

(2) The base cost-to-charge ratio for an out-of-state hospital shall be calculated in the same manner as for an in-state hospital, using Worksheets A and G-2 of the HCFA 2552.

(3) Out-of-state ambulatory surgery centers having no contiguous Kentucky counties shall be assigned a cost-to-charge ratio equal to seventy (70) percent of the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals.

Section 7. Reports to be Filed by Hospitals. Each bill submitted by a hospital pursuant to this administrative regulation shall be submitted on a

statement for services, Form UB-04 (formerly UB-92), [~~uniform billing form~~] as required by 803 KAR 25:096 [~~pursuant to KRS Chapter 216~~].

Section 8. Billing and Audit Procedures. (1) A hospital providing the technical component of a procedure shall bill and be paid for the technical component.

(2)(a) An independent practitioner providing the professional component shall bill for and be paid for the professional component.

(b) An independent practitioner billing for the professional component shall submit the bill to the insurer on the appropriate statement for services, HCFA 1500, as [~~billing form~~] required by 803 KAR 25:096 [~~pursuant to KRS Chapter 216~~].

Section 9. Miscellaneous. (1) A new hospital shall be required to file a letter with the commissioner [~~executive director~~] setting forth the start and end of its fiscal year within ninety (90) days of the date it commences operation.

(2)(a) An independent practitioner who does not receive direct compensation from the contracting hospital shall use the statement for services [~~forms~~] required by 803 KAR 25:096 [~~pursuant to KRS Chapter 216~~] when billing for professional services and shall be compensated pursuant to the Workers' Compensation [~~Kentucky~~] Medical Fee Schedule for Physicians incorporated by reference in [~~adopted pursuant to~~] 803 KAR 25:089.

(b) An independent practitioner who is directly compensated for services by the contracting hospital shall not bill for the service, but shall be compensated pursuant to the practitioner's agreement with the hospital.

(c) The hospital may bill for the professional component of the service under the Workers' Compensation Medical Fee Schedule for Physicians if the independent practitioner is directly compensated for services by the contracting hospital [~~in these circumstances~~].

(3) A hospital-based practitioner shall not bill for a service he performs in a hospital if the service is regulated by 803 KAR 25:089, but he shall receive payment or salary directly from the employing hospital.

[~~(4) Unbundling shall not be practiced.~~]

Dwight T. Lovan, Commissioner
Department of Workers' Claims

3-12-2009
Date

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 803 KAR 25:091
Contact persons: Thomas A. Dockter and Karen T. Meier, Office of General Counsel

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation sets forth the hospital fee schedule and regulates hospital fees and supplies provided to workers' compensation patients.

(b) The necessity of this administrative regulation: Pursuant to KRS 342.035, the Department of Workers' Claims is charged with the duty of setting fee schedules, and KRS 342.020 requires that hospital treatment be reimbursed on behalf of injured workers.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation sets forth how hospital fees and supplies are reimbursed.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation sets forth requirements for charging and reimbursing for hospital treatment of injured employees.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The Department of Workers' Claims will recalculate the cost-to-charge ratios to keep all charges at certain levels and avoid the impact of enormous markups for individual services. This approach should protect claimants, insurance carriers, and avoid a huge administrative burden on hospitals.
(b) The necessity of the amendment to this administrative regulation: It is imperative to keep medical costs within the workers' compensation system comparable to health insurance costs. Some charges for implants and DME had been five (5) times the costs of the equipment. The fees must be fair, current, and reasonable in comparison to fees paid by health insurers according to KRS 342.035. The new calculations for the hospital's cost-to-charge ratios should make the fees fair and reasonable without having a specific carve-out.
(c) How the amendment conforms to the content of the authorizing statutes: The amendments make the fees fair, current, and reasonable for similar treatment as paid by health insurers.
(d) How the amendment will assist in the effective administration of the statutes: The certainty of these hospital charges should reduce medical fee dispute

issues in this area. Hospitals will avoid administrative costs. Claimants and insurance carriers will get more consistent charges from hospitals.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Injured employees, hospitals, medical providers, insurance carriers, self-insurance groups, individual self-insurers and third party administrators.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: The Department of Workers' Claims will calculate the hospital cost-to-charge ratio pursuant to the new calculation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Some hospitals will receive a different cost-to-charge ratio which is designed to provide fair and consistent charges.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Insurance carriers, self-insured groups and individual self-insured employers will receive consistent prices for hospital services. Anytime medical costs are reduced, employers could benefit on workers' compensation insurance policies.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:
(a) Initially: The Department of Workers' Claims will use normal budget to implement administrative regulation. There would be no cost.
(b) On a continuing basis: No additional cost.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Workers' Claims' budget will be used which is restricted funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fees or funding will be increased. Payments to hospitals may be reduced and for some they may be increased.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: Hospitals cost-to-charge ratios are adjusted by new calculation. This should result in more consistent and fair charges.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied because it applies to all hospitals and other parties in an equal manner to a workers' compensation claim.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation No. 803 KAR 25:091

Contact Persons: Thomas A. Dockter
Karen T. Meier

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments, or school districts)?

Yes __√__ No _____

If yes, complete questions 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? All parts of government with employees

3. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 342.035

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. As an employer, there may be some increased costs for medical services. It is impossible to estimate not knowing what medical services will be needed by injured workers. Pursuant to KRS 342.035, the fee schedule is designed to be similar to commercial costs for similar procedures.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenue generated

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? No revenue is generated

(c) How much will it cost to administer this program for the first year? No new administration costs

(d) How much will it cost to administer this program for subsequent years? No new administration costs

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: